

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 251

00839

251

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ada Edgar Bell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Salem Conn.

Location

Dr. Edgar L. Lane

Edgar L. Lane

Means of injury

Address

Jan. 2 1947

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Ind.

County

Queen Anne

City or town

Rural Church

Tidewater

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 30 1946 to Jan. 6 1947

and that I last saw her alive on

Immediate cause of death

Hypertension

DURATION

Due to

Due to

Other condition

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

JAN 20 1947

BUREAU F B I

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00840

CERTIFICATE OF DEATH

131a
Reg. Dist. No.

2510

1. PLACE OF DEATH:

County.....

Queen Anne

City or town.....

Wilmington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Several months

Hospital, Institution, or street address where death occurred:

Wilm. Nursing Home

How long in hospital or institution?

3. (a) FULL NAME

Julia E. Bell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

July 21 1867

8. AGE:

Years

Months

Days

If less than one day

79

5

30

hrs.

min.

9. Birthplace.....

Bucks Co. Penn.

(Town, county, and state)

10. Usual occupation.....

Nursing

home

11. Industry or business

Nursing

home

12. Name.....

Julia E. Bell

13. Birthplace

Bucks Co. Pa

14. Maiden name.....

Julia Cochell

15. Birthplace

Bucks Co. Pa

16. Informant.....

Mrs. Alice B. Baile (sister)

Address

207 Wash. Ave. Chestertown, Maryland

Burial

Date thereof.....

(month) (day) (year)

(Burial, cremation, or removal. Which?)

So. in M.E.

Cemetery or crematory

Upper Falls, Maryland

Location

Upper Falls, Maryland

18. Funeral director.....

Wm. V. Williams

Address

Chesapeake, Maryland

19. (Date rec'd by registrar)

1-22-47

Edgar S. Lane

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Baltimore

City or town.....

Baltimore

County.....

Baltimore

Street No.....

207

Wash. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Jan. 20

1947 at 24 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 6

1947

to Jan. 20 1947

and that I last saw her alive on Jan. 19 1947

1947

Immediate cause of death.....

Natural death

DURATION

3 days

Due to.....

Chronic Myocarditis

DURATION

3 days

Due to.....

Chronic Enteric Inflammation

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

Injured at work?

23. SIGNATURE.....

Marshall Davis

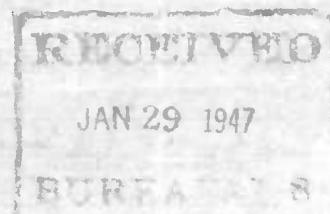
M.D. or other

Address.....

Wilmington, Del.

Date signed 1/20/47

Marvin U. Williams
Chesterboro Md.



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*Evidence for change of
age is shown on
S 109 - 3/27/47*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00841

251

CERTIFICATE OF DEATH

30g
Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Queen Anne

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Marian Elizabeth Bratcher

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Fem.**Col.**Married*

6. (b) Name of husband or wife.....

Charles Bratcher

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

June 1901

8. AGE:

Years *45*Months *46*

Days

If less than one day

hrs.

min.

9. Birthplace.....

Queen Anne Co. Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business.....

Jewelry Cooper

MOTHER FATHER

12. Name.....

Jessie Cooper

13. Birthplace.....

Q. A. Co. Md.

14. Maiden name.....

Doris Frances

15. Birthplace.....

Q. A. Co. Md.

16. Informant.....

Charles Bratcher

Address

Burial

Date thereof.....

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Pondtown

Cemetery or crematory.....

Pondtown Md.

Location.....

Pondtown Md.

18. Funeral director.....

Edgar H. Lane

Address

Church Hill Md.

19. (Date rec'd by registrar)

*1-31**47**Edgar H. Lane*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Ind

County.....

Queen Anne

City or town.....

Pondtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Jan. 28 1947 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 1946 to Dec. 1946

and that I last saw h.c.f. alive on December 1946

Immediate cause of death.....

Pulmonary edema

DURATION

Due to.....

Myocardial insufficiency

Due to.....

Hypertension ; hypertensive cardiovascular disease

Other conditions.....

Syphilis ; malnutrition ; aritamnrosis

(Include pregnancy within 8 months of death)

Major findings or operations.....

None

Date of op.....

Autopsy results.....

None

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

A. R. Corryla, M.D.

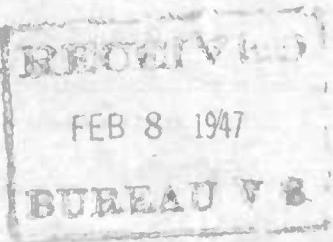
M. D. or other

Address.....

Chestertown, Md.

Date signed.....

1-31-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01036

CERTIFICATE OF DEATH

Reg. Date No. 2530

1. PLACE OF DEATH:

County... *Baltimore County*City or town... *Baltimore*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... *About 43*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Catherine Brown

4. Sex

Female

5. Color or race

Col.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Roderick Brown

(B.c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 3. 1873

8. AGE:

Years 63	Months 3	Days	It less than one day hrs. min.
-------------	-------------	------	--

9. Birthplace

Charles City Virginia

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

own home

MOTHER FATHER

12. Name... *unknown*

13. Birthplace

14. Maiden name... *unknown*

15. Birthplace

16. Informant... *Roderick B. Brown*

Address

*Baltimore*17. Buried... *Buried* Date thereof... *Jan. 5 47*

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory... *Baltimore Cemetery*Location... *Baltimore*18. Funeral director... *John A. Henry*Address... *Cambridge Md.*

19. Feb. 5 1947

(Date rec'd by registrar)

Elizabeth Hayes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Maryland* County... *Baltimore County*City or town... *Baltimore* (If outside city or town limits, write RURAL and give nearest town)

Street No... (If rural, give LOCATION)

2.(a) If veteran, name war...

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... *Jan. 2.* 1947 at 9³⁰ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 46 to *Jan. 2.* 1947,and that I last saw her alive on *Jan. 1.* 1947.

Immediate cause of death...

coronary occlusion DURATION *Jan. 2.* 1947Due to *atherosclerosis* *several days*Due to *sclerosis coronary arteries* *Jan. 2.* 1947

Other conditions...

(Include pregnancy within 3 months of death)

Major findings at operation... Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

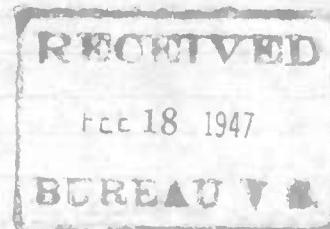
Means of injury... Injured at work?

23. SIGNATURE... *Theodor Sattelmaier M.D.* M. D. or otherAddress... *Heightsville* Date signed *Jan. 4 47*

RECEIVED BY THE FEDERAL BUREAU OF INVESTIGATION

FEDERAL BUREAU OF INVESTIGATION

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1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00842

CERTIFICATE OF DEATH

131a
Reg. Dist. No. 2540

1. PLACE OF DEATH:

County.....

Queen Anne

City or town.....

near Queenstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

8 yrs.

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Laura T. Fusselbaugh

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

Wm H. Fusselbaugh

7. Birth date of deceased (mo., day, yr.)

Sept. 7-1858

6.(c) If alive, give age years

8. AGE:

Years
88Months
4Days
18

If less than one day

hrs. min.

9. Birthplace.....

Baltimore

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

MOTHER FATHER

12. Name.....

Wm Henry Hickman

13. Birthplace

Baltimore, Maryland

14. Maiden name.....

Laura Jane Hooper

15. Birthplace

Baltimore, Maryland

16. Informant.....

Mrs J. Edg. Bryan (daughter)

Address

Queenstown MD

17. Burial

Date thereof Jan. 27, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Greenmount

Location

Baltimore, Maryland

18. Funeral director.....

Stewart & Meyer

Address

118 W. North Ave, Baltimore, Md.

19. Date rec'd by registrar

Jan. 25-1947

(auto rec'd by registrar)

Elaine Armstrong

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

MD

County.....

Queen Anne

City or town.....

near Queenstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

✓

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 25

1947 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1-1946 to Jan 25, 1947

and that I last saw her alive on Jan 22, 1947

Immediate cause of death.....

Chronic Intercostal Pleuritis

DURATION

Due to.....

Due to.....

Other conditions.....

Heart Constrictor

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Mr. Harvey Fisher

M. D. or other

Couteville MD Date signed 1/25/47

Address

RECEIVED

FEB 4 1947

BREAKFAST

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00843

CERTIFICATE OF DEATH

Reg. Dist. No.

251

93d

1. PLACE OF DEATH:

County..... Queen Anne

City or town..... Sudlersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all time

Hospital, institution, or street address where death occurred: Sudlersville

How long in hospital or institution?

3. (a) FULL NAME

Emma Harding Gillespie

4. Sex

F W Single

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) April 28 1880

8.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
66 3 13 hrs. min.9. Birthplace..... Centreville Queen Anne Co Md.
(Town, county, and state)

10. Usual occupation..... house keeper

11. Industry or business..... home

12. Name..... William J. Gillespie

13. Birthplace..... New York City N.Y.

14. Maiden name..... Esther Power

15. Birthplace..... Lake Simcoe Canada

16. Informant..... Mrs Anna G. Yarnall

Address..... Sudlersville, Maryland

17. Burial Date thereof..... 1/17/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Sudlersville

Location..... Sudlersville Maryland

18. Funeral director..... Marion V. Williams

Address..... Chestertown, Maryland

19. Date rec'd by registrar..... 1-16 1947

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Queen Anne

City or town..... Sudlersville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 15 1947 at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13 to Jan 15 1947

and that I last saw him alive on Jan 15 1947

Immediate cause of death.....

Cerebral Oedema Dilated

DURATION

Due to..... Chronic Hypertension

Due to..... Malignant Hyperplasia

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

Injured at work?

23. SIGNATURE..... C. Nuttall Esq.

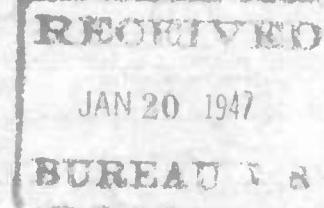
M. D. or other

Address..... Chestertown, Maryland

Date signed..... 1/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED BY TELETYPE STATE DEPARTMENT
JAN 20 1947
BY TELETYPE REGISTERED



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01-37

CERTIFICATE OF DEATH

Reg. Dist. No.

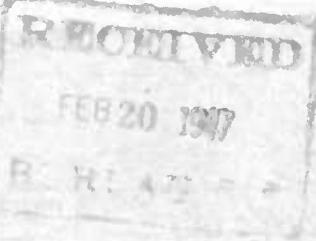
251

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)		2. USUAL RESIDENCE (HOME) OF DECEASED: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)	
How long in above place of death?..... Hospital, institution, or street address where death occurred..... How long in hospital or institution?.....		Street No. (If rural, give LOCATION)	
3. (a) FULL NAME <i>Elvie Calobezano</i>		3. (b) Social Security Number	
4. Sex..... Female Colored Married		5. Color or race..... 6. (a) Single, married, widowed, or divorced..... Married	
B. (b) Name of husband or wife..... <i>Stephens Calobezano</i>		6. (c) If alive, give age..... years	
7. Birth date of deceased (mo., day, yr.) <i>Dec 19 1890</i>		8. AGE: Years _____ Months _____ Days _____ If less than one day <i>80 11 00</i>	
9. Birthplace..... (Town, county, and state) <i>Bethel Monroe N.C.</i>		10. Usual occupation..... <i>Housewife</i>	
11. Industry or business..... <i>None</i>		12. Name..... <i>Edgar S. Lassan</i>	
13. Birthplace..... <i>Bethel Monroe N.C.</i>		14. Maiden name..... <i>Edith Knudsen</i>	
15. Birthplace..... <i>Bethel Monroe N.C.</i>		16. Informant..... <i>Mother</i>	
Address..... <i>Bethel Monroe N.C.</i>		17. Burial..... (Burial, cremation, or removal. When?) <i>Burial Jan 26-47</i>	
Cemetery or crematory..... <i>Bethel Cemetery</i>		Date thereof (month) (day) (year) <i>Jan 26-47</i>	
Location..... <i>near Chesterton Ind.</i>		18. Funeral director..... <i>Edgar S. Lassan</i>	
Address..... <i>Church Hill Ind.</i>		19. Date rec'd by registrar..... <i>Jan 24 1947</i>	
		Signature..... <i>Edgar S. Lassan</i>	
		M. D. or other <i>Alfred Heekin</i>	
		Date signed..... <i>Feb 7 1947</i>	
MEDICAL CERTIFICATION			
20. DATE OF DEATH..... <i>January 24 1947</i>			
I CERTIFY that death occurred on the date above stated; that I attended deceased from <i>January 24 1947</i> to <i>January 26 1947</i> , and that I last saw her <i>January 24 1947</i> alive on <i>January 26 1947</i> .			
Immediate cause of death..... <i>Heart Disease</i>			
Due to..... <i>Night Blood Pressure</i>			
Due to..... <i>Night Blood Pressure</i>			
Other conditions..... <i>None</i>			
(Include pregnancy within 3 months of death)			
Major findings of operations..... <i>None</i>			
Date of op.			
Autopsy results..... <i>None</i>			
PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following:			
Accident, suicide, or homicide..... <i>None</i>			
Where did injury occur? (City or town) (County) (State)			
Injured at home, farm, industry, public place (where?) <i>None</i>			
Means of injury..... <i>None</i>			
Injured at work? <i>None</i>			
23. SIGNATURE..... <i>Edgar S. Lassan</i>			
Address..... <i>Church Hill Ind.</i>			

PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VSA15





1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00845

CERTIFICATE OF DEATH

Reg. Dist. No. 2052

1. PLACE OF DEATH:

County.....*Baltimore*
City or town.....*Baltimore*

(If outside city or town limits, write RURAL and give nearest town)

all her life

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ella Mitchell

4. Sex

Female | Color or race *Colored* | 6.(a) Single, married, widowed, or divorced *Widowed*

6.(b) Name of husband or wife

William Mitchell

7. Birth date of deceased (mo., day, yr.)

March 7 - 1876

6.(c) If alive, give age years

8. AGE:

Years *70* Months *10* Days *23* If less than one day
hrs. _____ min. _____

9. Birthplace

near Centreville Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Aleck Thompson

12. Name

don't know

13. Birthplace

Emma

14. Maiden name

don't know

15. Birthplace

Hazel Mitchell

16. Informant

Centreville Maryland

Address

Burial Date thereof *Feb 2-47*
(Burial, cremation, or removal, which)

(month) (day) (year)

Cemetery or crematory *Chesterville*Location *Centreville Maryland*18. Funeral director *Proctor Bros*Address *Centreville Maryland*19. Feb. 1 - 1947 *Ella Armstrong*

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Queen Anne's*City or town.....*Centreville*

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH *Jan 30 1947* a.m. *8:30*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan 15 1947* to *Jan 30 1947* and that I last saw her *alive* on *Jan 30 1947*.

Immediate cause of death

Paralysis

Due to

My pernicious

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

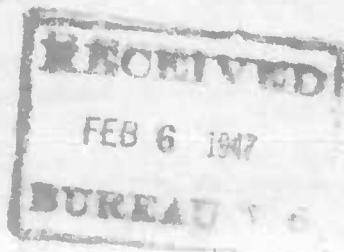
Injured at work?

23. SIGNATURE *H. J. Westmore*

M. D. or other

Address *Centreville* Date signed *31/1/47*

Address



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00846

CERTIFICATE OF DEATH

Reg. Dist. No. 2520

50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15
9-45-15

1. PLACE OF DEATH:

Queen Anne's
Centerville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Eileen Morris

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Arthur L. Morris

6. (c) If alive, give age

63

years

7. Birth date of deceased (mo., day, yr.)

April 12-1883

8. AGE:

63

Years

8

Months

25

Days

If less than one day

hrs.

min.

9. Birthplace

Caroline Co Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

George Connor

13. Birthplace

Caroline Co Maryland

14. Maiden name

Mary Jane Grenely

15. Birthplace

Caroline Co. Maryland



1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00847

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County..... Queen Anne
 City or town..... Near Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 30 Years

Hospital, institution, or street address where death occurred:

None
How long in hospital or institution?

3. (a) FULL NAME

Arcadia Lindale Noll

4. Sex..... Female	5. Color or race..... White	6.(a) Single, married, widowed, or divorced..... Married
--------------------	-----------------------------	--

6.(b) Name of husband or wife..... Edward Noll
 6.(c) If alive, give age..... 84 years

7. Birth date of deceased (mo., day, yr.)..... March 22, 1869

8. AGE: 77 Years 10 Months 19 Days If less than one day
 hrs. min.

9. Birthplace..... Delaware
 (Town, county, and state)

10. Usual occupation..... Housework

11. Industry or business..... Home

12. Name..... Jonathan M. Abbott

13. Birthplace..... Delaware

14. Maiden name..... Tamey Jane Buller

15. Birthplace..... Delaware

16. Informant..... Mrs. Esther Larsen (Daughter).

Address..... Chestertown R.D. Md.

17. Burial..... Burial
 (Burial, cremation, or removal, Which?)..... Date thereof..... 2 - 1 - 47
 (month) (day) (year)

Cemetery or crematory..... Old Fellows

Location..... Canons, Del.

18. Funeral director..... Dr. A. Berry, Sr.

Address..... Fellows, Del.

19. Date rec'd by registrar..... Jan. 30, 1947
 (Date rec'd by registrar)..... Edgar L. Lane
 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Queen Anne

City or town..... Near Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war..... No

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 30, 1947 12,30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 11. 1944 Jan 30 1947
 and that I last saw her alive on Jan 30. 1947

Immediate cause of death..... Toxemia DURATION
 Several Days

Due to..... Carcinoma Uterus and Appendages
 3 yrs

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... No operation

Date of op.....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... None Date of.....

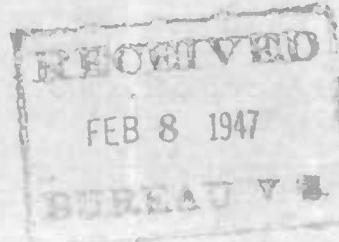
Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?)..... None

Means of injury..... None Injured at work?

23. SIGNATURE..... Hazel Hines

M. D. or other..... Date signed..... Jan 30/47



2 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00848
254

Reg. Dist. No.

1. PLACE OF DEATH:

County... Queen Anne's

City or town... Chesapeake

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

60 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Catherine Thompson

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Eugene Thompson

76

7. Birth date of deceased (mo., day, yr.)

Aug. 21. 1875.

8. (c) If alive, give age years

8. AGE:

Years
71Months
4Days
19If less than one day
hrs. min.

9. Birthplace

Monroe Somerset Co. Md.

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

Wesley Lawrence

Somerset Co. Md.

12. Name

MOTHER FATHER

13. Birthplace

Somerset Co. Md.

14. Maiden name

Hester Bosman

15. Birthplace

Somerset Co. Md.

16. Informant

Mrs. Hallie M. Clark

17. Burial

Chesapeake Md.

Address

18. Cemetery or crematory

Stevensville

Location

Stevensville Maryland

19. Funeral director

Tolson Bros

Address

Centreville Maryland

20. Date rec'd by registrar

Jan. 10 1947 Helen M. Adridge

Date signed

1/9/47.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Queen Anne's

City or town... Chesapeake

(If outside city or town limits, write RURAL and give nearest town)

Street No....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9th

1947 at 9 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to January 9, 1947.

and that I last saw her alive on January 9, 1947.

Immediate cause of death

Adeno - carcinoma of

left breast with

Metastases in lung + spine

DURATION

about 5 years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

breast

Amputation of left

& Ray Statement Feb. 1942

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Theodor Sattelmair M.D.

M. D. or other

Address... Stevensville

Date signed 1/9/47.

RECEIVED

JAN 14 1947

BUREAU OF S

1-35

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

926

Registration Dist. No. 251

1. PLACE OF DEATH

County Queen Ann

Village or City Pond Town

Length of residence in city or town where death occurred 5 yrs.

No.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

St., Ward

mos.

ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Hulda E. Turner

(a) Residence: No. Pondtown Md (Millington, Md) St., Ward.

If U. S. Veteran, specify WAR no

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE Col

5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)

Married

5a. If married, widowed, or divorced
HUSBAND OF
(or) WIFE OF

Rev. W. O. Turner

6. DATE OF BIRTH (month, day, and year)

April 25, 1893

7. AGE

Years 53

Months 3

Days

If LESS than
1 day, _____ hrs.
or _____ min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.

house wife

9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation

12. BIRTHPLACE (city or town)

(State or country)

Salisbury Md
Wicomico Co.

MOTHER

FATHER

13. NAME James E. Brown

14. BIRTHPLACE (city or town)
(State or country)

Maryland

15. MAIDEN NAME Hester Wright

16. BIRTHPLACE (city or town)
(State or country)

Maryland

17. INFORMANT Rev. W. O. Turner

(Address)

Millington, Md. Box #74

18. BURIAL, CREMATION, OR REMOVAL

Place

Mt Pleasant Cemt

Date Feb 2, 1947

19. UNDERTAKER Calvin Clark

(Address)

102 S. Queen St., Dover, Del.

20. FILED Jan. 28, 1947

(Address)

Edgar L. Lane
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY. That I attended deceased from

I last saw him alive on to have occurred on the date stated above, at p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Bilateral Heart Disease

Other Contributory Causes of importance

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide

Date of Injury

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

M. O.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gallstones	May 1, 1923

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN
